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ABSTRACT

Speech plays important and complex roles in self-regulation and is experienced in several distinct forms: as a social-discursive mode of communication and direction (social speech), as vocalizations directed to the self rather than to others (private speech), and as the phenomenologically subjective "interior dialogue" through which the personality regulates and directs its own thoughts and actions (inner speech). This paper surveys the levels of discursive interaction that occur during the process of psychotherapy, and makes explicit the assumptions concerning these interactions as they occur in two major language-based approaches to psychotherapy: cognitive therapy and psychoanalysis. The focus of the paper is primarily on Vygotsky's developmental model of inner speech, that is, the progression from social speech, to private speech, and finally, to inner speech--the principle of self-regulatory mechanism of the personality. Verbalization in psychotherapy plays at least two distinct roles. First, verbalization allows a client to externalize her self-regulatory inner speech, making it available for conscious analysis and revision. Second, the speech interactions that occur between therapist and client during psychotherapy become the basis for subsequent revisions of the client's inner dialog. Both directive and non-directive therapeutic styles make extensive use of discursive interaction as the fundamental "medium of exchange" between therapist and client. Vygotsky's developmental model of inner speech effectively illustrates the discursive levels of psychotherapeutic interaction. (LLL)

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LEVELS OF DISCOURSE IN PSYCHOTHERAPEUTIC INTERACTIONS

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INTRODUCTION

Speech plays important and complex roles in self-regulation and is experienced in several distinct forms: as a social-discursive mode of communication and direction (social speech), as vocalizations directed to the self rather than to others (private speech), and as the phenomenologically subjective "interior dialogue" through which the personality regulates and directs its own thoughts and actions (inner speech). Yet, most handbooks of clinical procedure focus explicitly on the dynamics of personality structures, rather than on the implicit role of language as a self-regulatory instrument of the personality; as a consequence, this latter domain remains less well-explored. The purpose of this paper is to survey the levels of discursive interaction that occur during the process of psychotherapy, and to make explicit the assumptions concerning these interactions as they occur in two major language-based approaches to psychotherapy: cognitive therapy and psychoanalysis. The focus of the paper will be primarily upon Vygotsky's developmental model of inner speech, that is, the progression from social speech, to private speech, and finally, to inner speech--the principal self-regulatory mechanism of the personality.

Specific questions posed by this paper involve: (1) what role, or roles, does verbalization play in psychotherapy?, (2) how important is the process of verbalization to the successful outcome of the therapy?, and (3) what specific levels of discourse can be identified in psychotherapeutic interactions? The first part of this paper presents a historical and critical survey of the major theoretical works in this domain of inquiry. Included in this survey are selected works by the American pragmatist George Herbert Mead (1863-1931) and the Russian psycholinguist Lev Semyonovich Vygotsky (1896-1934) on the social origins of inner speech, as well as more recent research on clinical applications of these and related concepts.

In the second part of the paper, a multileveled model of psychotherapeutic discourse--involving the internalization of social speech as a primary means of self-regulation--is presented, along with published verbatim transcripts of psychotherapy sessions that illustrate these varied levels of discursive interaction *in vivo.*

While there are estimated to be more than 250 different therapeutic approaches currently in use, this paper focuses upon two of the most basic theoretical orientations from which many of these other hybrids spring: cognitive therapy (as an example of a "directive" therapeutic approach), and psychoanalysis (as an example of a "nondirective" therapeutic approach). Newly translated research on psycholinguistics by L. S. Vygotsky is cited to lend support to the theoretical assertions of cognitive therapy.

PART ONE

SOCIAL, PRIVATE, AND INNER SPEECH: A HISTORICAL SURVEY

George Herbert Mead and early European psychology

One of the earliest formulations of the concept of internalized social speech as an important self-regulatory mechanism is found in the writings and lectures of George Herbert Mead. Mead's educational backround, prior to his appointment to a professorship at the University of Chicago in 1894, involved a close relationship with European psychology, in particular, the German theorist and researcher Wilhelm Max Wundt, M.D., Ph.D. (1832-1920). Mead's interest in the social origins of self, and all that this implies, can be traced at least partially to Wundt's intellectual influence. A brief examination of Mead's association with Wundt will serve to locate the origins of Mead's theoretical position within the wider concerns of late 19th-century European psychology and, at the same time, will serve to clarify how Mead's position differs from Wundt's.

Mead received the degree of *Philosophiæ Doctor* from Wundt's Psychological Institute (the first ever created) at the University of Leipzig. Wundt, though principally a physiologist, also held a chair as professor of philosophy at Leipzig. Since much of Wundt's work has never been completely translated into English, his writings are known to most American psychologists in only a partial and fragmentary way.

Wundt's historical importance rests primarily upon his 'physiological psychology' (he had been, for a time, a research assistant of Hemholtz at the University of Heidelberg), and also upon his consolidation and institutionalization of psychology as a science in its own right.[1] Along with the earlier psychophysics research of Gustav Fechner and E. H. Weber, Wundt's research into the elementary structures of conscious--those writings that were made available in translation--provided a kind of access road by means of which late 19th-century American researchers came to know European psychology. Building upon his interests in physiology and psychophysics, Wundt later introduced what he termed *Völkerpsychologie* (Cultural Psychology, [2] also called Folk Psychology) in his ten volume collection by the same name. The few fragmentary translations of *Völkerpsychologie* (1900-1909) available at that time were overshadowed, however, by the rise in German nationalism prior to the outbreak of World War I. During those chaotic times, translators seized upon what they construed to be nationalistic chauvinism in Wundt's work, causing much of it to be dismissed as German racist propaganda. It has, as yet, never been fully translated into English.

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[1] adapted from a biography presented in William S. Sahakian (1975) *History and systems of psychology*. New York: John Wiley and Sons. pp. 148-54.

[2] German psychologists have criticized Richard Schweder and other English speaking researchers for their evident ignorance of European psychology demonstrated by Schweder's recent claim to have invented a "cultural psychology." Cultural psychology is known to have originated early in this century with Wilhelm Wundt, founder of Experimental Psychology. Another early example of cultural psychology is the Soviet historical-cultural approach (Vygotsky 1924). (Quarterly Newsletter of the Lab of Comparative Human Cognition, Vol. 12 No. 1, January 1990. p.3.

Wundt's multivolume work set out to investigate the influence of myth, custom, and language on the individual psyche; in Wundt's words, to explore "those mental products that are created by a community of human life and are, therefore, inexplicable in terms of merely individual consciousness" (1916, p. 3; cited in Sahakian, 1975, p. 153). His concept of a "collective consciousness", shaped and communicated by means of language, provided a neat explanation for the presumed cognitive differences among various ethnic groups. Wundt's approach to *folk psychology* , however, continued to stress the primacy of the individual over the social, stemming perhaps from Wundt's early involvement with psychophysics and its emphasis upon the individual organism. George Herbert Mead's theoretical perspective on the social origins of the self can be regarded as a response to Wundt's earlier *folk psychology* with further emphasis placed upon the social dimension. (The same can be said of L.S. Vygotsky, who explicitly placed his own work in opposition to Wundt's.)

Mead's theory of consciousness: The I *and the* me

Mead's exposition of the social origins of consciousness are found mainly in the publication (posthumous) *Mind, Self, and Society* (1934), assembled from the lecture notes of Mead's students. In *Mind, Self, and Society* Mead considers the self to be a product of social interactions. He states,

> Only in terms of gestures as significant symbols is the existence of mind or intelligence possible; for only in terms of gestures which are significant symbols can thinking--which is simply an internalized or implicit conversation of the individual with himself by means of such gestures--take place. The internalization

> in our experience of the external conversations of gestures which we carry on with other individuals in the social process is the essence of thinking . . . .[3]

Mead uses the term *gesture* to refer to the entire range of behaviors found in communication, including not only speech but facial expressions, simple indicative bodily gestures such as pointing, and other communicative acts as well. This large, inclusive category has the virtue of subsuming a great deal of content, but it also creates a somewhat generalized idea of exactly what is being internalized. Vygotsky later clarified this somewhat overgeneralized concept by tracing the origins of speech to gestures--such as pointing--and introducing the idea of words as tools for the manipulation of thoughts (Vygotsky, 1929/1981).

Mead remained active as a teacher and theorist on concepts of mind and self from 1894 through the 1920s. Throughout this period, while a faculty member in the department of philosophy at the University of Chicago, Mead developed his concept of mental processes as internal dialogs between "the self as subject" (the *I*) and "the self as object" (the *me*). The distinctive feature of the higher cognitive processes is that they allow a person to figuratively "stand apart from himself" and view his own thought processes as objects from a meta-cognitive perspective. For Mead, the sense of who we are is derived from one's history of interactions with social others, whose reactions reveal what we have meant to them. Thus, the self is largely an internalization of what we have meant to others.[4]

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[3] George Herbert Mead, excerpt from *Mind, Self, and Society*, in *George Herbert Mead On Social Psychology*, ed. Anselm Strauss (Chicago: University of Chicago Press, 1934/1969), p. 159.

[4] Erik Erickson's later concept of *mutual regulation* echoes this idea in stating that parental responses to the infant set the stage for the infant's later knowledge of its self.

There exists in each person a concept of him-/herself, a *me* , for every significant other with whom he/she has entered into a relationship. As the personality evolves, further involvements with others results in the accumulation of more *me* s, which further shape and define the personality. This concept is similar to Harry Stack Sullivan's concept of the *personality multiplex*, in which the self is defined entirely by its vast repertoire of social roles. In Sullivan's model, these social roles constantly emerge and recede--much like the singers in a chorus who take center stage for a brief moment, then fade into the backround.

But Mead's concept of the self includes more than this accumulation of historical *me* s. There is, in addition to this idea of "the self as object", another part of the self which Mead calls the *I* . Unfortunately, Mead is less clear in his explanation of exactly what the *I* involves. For Mead, the *I* represents our spontaneous and momentary responses. It is the *I* in us that is capable of surveying our accumulated *me* s, and yet the *I* is never known to us, until it has, itself, taken its place among our historical selves--thus, memory plays an important role in distinguishing between these two components of self (the *I* is always experienced directly and immediately, but only becomes knowable--in the subjective, phenomenological sense--after it has entered into the realm of *ex post facto* experience). There is an element of incalculability present in the *I* that is only resolved by its happening; for Mead, the *I* is transcendent and noumenal in its nature, whereas the me is immanent and phenomenal.

Mead argues for a cultural-philosophical view of the organism, while de-emphasizing its personal and biological dimensions. While the self depends on social communication, such patterns of social involvement are "biological givens", that is to say, behavior intrinsic to the organism. Human beings are social by their very natures, and manifest this fact in the social acts of reproduction, childcare, defense, and so forth. This social imperative is the heritage of our evolution, but the most important dimension of social interaction is human language (which includes, for Mead, communicative gesture as well as vocalization). It is through the process of communication--in its largest sense--that

the self is constituted. And it is through language that we are capable of developing an internal dialog between the *I* and the *me*, resulting in self-consciousness. This internal dialog is a reflexive one, modeled upon our interactions with other people. Under conditions of stress (either of a positive or of a negative sort), we talk aloud as if in an effort to stabilize ourselves through a reflexive "social" interaction with another part of ourselves.

In cases of psychopathology, this internal dialog is still present but takes on regressive and often obsessional forms. Auditory hallucinations (a patient's hearing voices that comment on her actions as she performs them, or are accusatory in tone) are a symptom commonly associated with certain forms of schizophrenia. Accusatory voices of this type say things that the patient cannot bear to say to herself; it is the patient's parental voice, the internalized mother or father--Freud's concept of the superego (*über-ich*)--that is speaking.

In summary, Mead's psychology emphasizes the idea that self-experience is the internalization of external processes of communication between the self and others. There can be no self-experience without the experience of others.

L. S. Vygotsky: the psycholinguistic approach to self

Lev Semyonovich Vygotsky (1896-1934), like many early European psychologists, was initially trained in academic areas outside of psychology; in Vygotsky's case, these areas were literature, philosophy, and law. Following his graduation from Moscow State University (Law degree, 1917) and Shanyavskiy University (studies in psychology, philosophy, and literature, 1914-17), Vygotsky returned to his hometown of Gomel, near Minsk in Byelorussia (the western part of European Russia). There he worked mainly as a teacher of deaf children. Then in 1924, Vygotsky received an appointment as Junior Staff Scientist--2nd Class, under Alexander Luria, at the Psychological Institute of the Krupskaya Academy in Moscow. Vygotsky finished a doctorate from Moscow State

University in 1925, and continued his defectology work with speech impaired, hearing impaired, and retarded children and adults.[5] From 1924-1934, Vygotsky also conducted research on child development most notably his studies on egocentric speech, children's play, and concept formation. Although Vygotsky died of tuberculosis only a decade later, he made fundamental contributions to the theory of cultural-historical development (also called the *sociohistorical theory*), which stressed the importance of social and environmental factors in human development. He pioneered the field of defectology--the Soviet equivalent of special education--and was the first to uncover the semantic disorganization in schizophrenics (Sahakian, 1975, p. 403). Philosopher of science Stephen Toulmin has called Vygotsky the "Mozart of psychology" (Toulmin, 1978).

Vygotsky's work extends the concept of the social origin of the self by fixing the locus of internalization more specifically within the domain of signs, rather than within the more generalized domain of "communication" as Mead had done. In Vygotsky's words,

> Thought development is determined by language, that is, by the linguistic tools of thought and by the sociocultural experience of the child. Essentially, the development of inner speech depends on outside factors; the development of logic in the child . . . is a direct function of his socialized speech. The child's intellectual growth is contingent on his mastering the social means of thought, that is, language." (Vygotsky, 1962, p. 51)

And, more succinctly,

> "The internalization of cultural forms of behavior involves the reconstruction of psychological activity on the basis of sign operations."(Vygotsky, 1978, p.57)

Vygotsky demonstrated that much of what had previously been regarded as innate behavior was, in actuality, learned behavior. Vygotsky regards all higher mental functions

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[5] Adapted from a detailed biographical sketch in Wertsch, J. V. (1985) *Vygotsky and the social formation of mind.* Cambridge, MA: Harvard University Press, chapter 1

as originating from *interpersonal* (social) interactions which are transformed (that is to say, internalized) into *intrapersonal* interactions. The child's social speech becomes internalized as self-regulating inner speech.

Closely allied to this idea is Vygotsky's concept of the *zone of proximal development*, which states that children function at a higher level of competence when they work under the guidance of an adult (or more capable peer) than when they work alone. In Vygotsky's own words, ". . . the zone of proximal development . . . is the distance between the actual developmental level of the child as determined by independent problem solving, and the level of potential development as determined through problem solving under adult guidance or in collaboration with a more capable peer." (Vygotsky, 1978, p.86)

In much the same way that tools allow us to exert influence upon external things, a system of signs (such as language) allows us to influence internal mental processes. The internalized social dialog (inner speech) enables us to master behavior by using words as tools for the manipulation of thoughts. According to Vygotsky, all higher mental functions appear first on the interpsychological plane and then on the intrapsychological plane (Wertsch, 1985 p.158). An effective teacher not only provides the social interaction that the child internalizes, but also provides *scaffolding* (ie., varying degrees of assistance) for the child's efforts at critical points, which helps the child to function at a new, higher level--the upper limit of the child's zone of proximal development (Wood, 1988).

Vygotsky introduced not only a theoretical model but also empirical methods for observing the internalization of social speech. Using Vygotsky's "microgenetic method" (basically a form of discourse analysis), James Wertsch was able to demonstrate, within a single observational session, the assimilation by a child (age 2.5 years) of his mother's social speech. Wertsch's (1980) study showed that fragmentary speech artifacts, such as partially asked questions which the child directed to himself during episodes of private speech, originated from questions which had been directed earlier to the child by his

mother. This demonstrates not only the child's internalization of her speech, but also the transformation that take place along the continuum from social speech to private (vocalized) speech, to inner (unvocalized) speech.

In Vygotsky's model of the development of inner speech, social speech represents the earliest developmental stage, followed by private speech (in which the child vocalizes aloud to himself). Following this stage, the child's speech is internalized as inner speech, and no longer vocalized. It is this internalized "silent speech" that allows the child to manipulate thoughts as if they were objects, to speak to and direct himself as if he were directing another person. In this form, inner speech becomes the metacognitive instrument fundamental to the concept of self, finding its parallel and theoretical forebearer in Mead's concept of the transcendental *I,* the noumenal counterpart to the historical, phenomenal *me.*

It is notable, from a theoretical as well as a historical viewpoint, that Vygotsky's model of the internalization of social speech is the exact reverse of Jean Piaget's developmental model of egocentric speech. As such, Vygotsky's model directly challenges the Piagetian paradigm in developmental psychology. In Piaget's model (Piaget, 1923/1973, pp. 63-65) *egocentric* speech--that is, idiosyncratic speech which serves no useful social or developmental purpose--is considered to be the earliest form of speech. According to Piaget, this early egocentric speech does not develop into "meaningful social speech" until the child is about seven years of age, which coincides with the period during which the child's emergent intellect enters the stage of concrete operations and becomes, for the first time, capable of truly realistic thought (Piaget, 1923/1973).

> . . . We may say that the adult thinks socially, even when he is alone, and that the child under seven thinks egocentrically, even in the society of others. . . . [This] is due, in the first place, to the absence of any sustained social intercourse among the children of less than 7 or 8, and in the second place, to the fact that the language used in the fundamental activity of the child--play--is one of gestures, movement,

> and mimicry as much as of words. There is, as we have said, *no real social life among children of less than 7 or 8 years* (1923/1973, pp. 60-61).

Piaget later revised this position (Piaget, 1945/1962, p. 131) to acknowledge--as Vygotsky had pointed out--that social speech does become internalized; yet, Piaget never acknowledged that egocentric speech, or internalized speech, served a self-regulatory function. For Piaget, egocentric speech as well as later inner speech were always a manifestation of egocentric thought and, therefore, were primarily expressive in character (that is, nonsocial, and not reality-oriented).

Psycholinguistic research has supported Vygotsky's model of inner speech and has largely discredited Piaget's model (*see* Berk, 1992). Issacs (1930) and McCarthy (1930) found that the type of non-reality oriented egocentric speech described by Piaget is rare, accounting for only 1/20th of the speech of 18- to 54-month old children. Furthermore, research has shown that private speech is multi-functional in character (Berk and Garvin, 1984), serving purposes of playful word-acquisition, self-regulation, reification of self-image, and emotional expression. It has also been demonstrated that private speech is modeled after social speech interactions, and that inner speech appears at the average mental age of 7 years.

In summary, Vygotsky's theoretical approach, like G. H. Mead's, considers the internalization of social communication to be a significant self-regulatory mechanism for the personality, but unlike Mead, Vygotsky's theoretical model stresses the character of internalized speech as a system of *signs,* or more specifically, *tools for the manipulation of thoughts.* Vygotsky established that the internalization of social speech follows a discrete developmental sequence (social speech--private speech--inner speech), and from this derived his concept of the *zone of proximal development* , the idea that an individuals learn how to regulate their own behavior and thought processes by collaborating with someone more competent or knowledgeable, and internalizing the social speech of that other.

Vygotsky believed that while there are always elementary mental functions that are not regulated by inner speech--like the natural biological processes found in animals and infants--internalized speech is always the essential instrumentality responsible for the creation and regulation of the higher cognitive processes. These higher cognitive processes include emotional responses, conceptual thought, imagination, perception, memory, volition, and attention. To clarify this, a memory can be spontaneously evoked by a sensory stimulus-association from the outside world (at the level of a more elementary function), but a memory can also be evoked deliberately by inner speech (at the level of a higher cognitive function).

The implications of these ideas in the domain of psychotherapy will be examined in the following section of this paper.

PART 2

LEVELS OF DISCOURSE IN DIRECTIVE AND NON-DIRECTIVE THERAPIES

Mead's and Vygotsky's concept of the self-regulatory nature of inner speech has important implications for psychotherapy. In terms of Vygotsky's theoretical model, most psychotherapeutic techniques can be regarded as an application of the zone of proximal development to the cognitive and/or affective processes of the personality. The interaction between the client and the therapist, and the client's subsequent internalization of the therapeutic dialogue, provides the positive therapeutic effect upon the client.

In this paper, the process of internalization will be examined from two different therapeutic perspectives: one a directive mode of therapy (cognitive therapy), and the other a non-directive mode (psychoanalysis). It is hypothesized that the levels of discourse in psychotherapeutic interactions will follow the Vygotskian developmental continuum of inner speech (social--private--inner speech) with the addition of regressive stages and

substages. The incidence of these stages will be illustrated through excerpts taken from verbatim transcripts of therapeutic interviews.

Non-directive therapy: Dimensions of discourse in psychoanalysis

The theoretical approach adopted by Breuer and Freud involved bringing the patient's previously blocked emotions to conscious awareness through verbalization, however, the specific techniques employed by both men differed somewhat. Breuer's elaboration of the "talking cure", was called the *cathartic method*--catharsis suggesting a purification or purgation. (The medical term *cathartic* denotes a compound used to stimulate purgation of the bowels.) Breuer's cathartic method employed hypnosis as a means of "widening the patient's consciousness" thereby allowing her access to repressed unconscious material, but he did not utilize hypnotic suggestion to influence the patient's thoughts or behavior. Under the enabling influence of hypnosis the patient recalled emotions, thoughts, and memories not otherwise accessible to her conscious mind. The patient was then able to unburden herself of these strong emotions, whose expression had been formerly blocked, by talking about them and allowing herself to re-experience, to *abreact*, them. This allowed for a more successful integration of the formerly repressed memories into the patient's conscious personality. The consequence of this abreaction was the symptom's disappearance.

Freud's first full treatment using Breuer's cathartic method occurred in the case of Elizabeth von R. (1892) and is detailed in *Studies on Hysteria* (Breuer and Freud, 1893/1955). Freud later discovered, however, that he could achieve the same results by using a "concentration" technique in lieu of hypnosis. In some respects Freud's method is the opposite of Breuer's; Breuer used hypnosis without suggestion, whereas Freud used suggestion without hypnosis. Rather than inducing a hypnotic trance state in the patient as Breuer had done, Freud simply had his patients assume a comfortable reclining posture while he, the therapist, was seated out of sight behind the patient. Freud then asked his

patients to ruminate upon anything that made itself available to their consciousness, to follow the vicissitudes of their thoughts wherever they might lead, as in a spontaneous conversation that moves--in Lewis Carroll's classic line--alternately to "cabbages and kings".[6] The patient was instructed to report as accurately as possible all of the thoughts she might have in the course of these reveries, withholding nothing, no matter how embarrassing it may seem. Thus, Freud's elaboration of Breuer's technique was still essentially a "talking cure."

Interestingly enough, in Freud's arrangement of the physical positions assumed by the therapist and client, the therapist becomes, for all intents and purposes, a disembodied voice that hovers over the client, making its presence known now and then when it asks a question or underscores a salient phrase, then returns to its vantage point somewhere above the recumbent analysand. The similarity between this physical arrangement and the client's own internal *mise en scene*, in which another "disembodied voice"--that of the introjected parent in the form of the *über-ich* (overself) or superego--figuratively hovers over the client, could hardly be dismissed as accidental. In psychoanalysis, the role of the superego (as played by the therapist), is all-accepting, all-tolerating, even of the client's most intimate resentments; a striking contrast to the overcontrolling character of the neurotigenic superego.

When a patient was unable to proceed beyond a certain point in her recollections, Freud applied a technique of suggestion involving the application of a slight pressure to the patient's head as a means of helping the patient to overcome the psychological *resistance* to uncovering the repressed memory. The latent symbolism of this act was a jarring or shaking loose of the "stuck" memory. Freud quickly abandoned this "hand pressure" technique as unnecessary, using *interpretation* alone to overcome the resistance. Although

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[6] From "The Walrus and the Carpenter" in *Alice in Wonderland.* "The time has come, the Walrus said, to talk of many things; of ships and boats and sealing wax, of cabbages and kings . . . "

Freud's technique is regarded as suggestion without the induction of a hypnotic trance state, it should be noted that the inward-turning reverie called for in Freud's method is similar in character to a light trance; this reverie no doubt facilitated the client's receptiveness to suggestion.

It was the psychoanalyst's role to listen to the recollections of his patient with an "evenly hovering attention", not restricting his attention to any particular avenue of thought, but moving easily along with the patient's utterances, receptive to any unexpected turns of the patient's recollections. The therapist functions like a mirror for the patient, joining his unconscious to the patient's, and slowly building a construction, or holistic sense of the patient's situation by piecing together the various interpretations gleaned from the patient's utterances, rather like an archaeologist reconstructing an ancient tomb from its fragmentary remains. This construction of repressed memories would then be laid before the patient for her consideration when the patient's *resistances* had been sufficiently overcome or resolved by *interpretations of defense*--a subprocess to which Freud gave ever greater emphasis in his writings. The patient's own immediate verbal response to the construction was judged by Freud to be of less significance than one might first suspect. If a patient spontaneously began to recall memories as a result of hearing the therapist's construction, that would seem to attest to the significance of the construction. At other times, however, a client might insist,"Yes, that's it" when presented with a construction, and yet continue to demonstrate through her behavior or utterances that the resistances to the repressed material were still in place. Similarly, a negative response by the patient might be equally as inconclusive in determining the significance of the therapist's construction. In some cases the client's resistance to uncovering the repressed material might also be acted out in certain behaviors rather than expressed verbally. An example of this may be seen in a situation where, for instance, the patient is harboring deep feelings of shame associated with a childhood sexual episode. The force of repression may become displaced onto the therapy itself, resulting in the patient's seeking to hide the fact of her therapy, as if in shame of it.

The image of the therapeutic process is a cyclical one; the patient provides the therapist with information through her recollections, which is then interpreted by the therapist and pieced together into a construction, the significance of which is determined by the patients further statements, recollections and behaviors; here, the therapist's sensitivity to the patient's recurring themes, motifs, and patterns of behavior plays an important role. The therapist must exercise his own intuitive sense in these matters.

During the course of the therapy, a concentration of emotional energy or *cathexis* forms between the patient and therapist resulting in a *transference* whereby the patient substitutes the therapist for an object of repressed desire. This transference, which may be of a positive or a negative type, is the force that gives power to the therapist's suggestions, and which allows the patient to effectively express those repressed emotions that were associated with the original object. In the famous case study of Anna O., the patient transferred her repressed Oedipal-erotic desires, originally directed toward her father, onto her physician, Dr. Breuer. The resulting positive transference was strong enough to elicit a reciprocal response from her physician in the form of a *countertransference*.

In classical psychoanalysis, the success of the psychoanalytic treatment was determined by the degree to which the symptoms of the illness under scrutiny had been eliminated. Freud himself recognized that a complete elimination of all symptoms was not always a realistic expectation, therefore in some cases the treatment was regarded as partially successful if the major symptoms were reduced sufficiently to allow the patient to return to a reasonably normal existence. Subsequent experience, however, has indicated that a spontaneous elimination of symptoms is not always the valid indicator of therapeutic success that it had once been thought to be. Patients may effectuate a temporary *flight into health* when threatened with the revelation of highly disturbing unconscious material.

Vygotsky's theory parallels Freud's psychoanalytic concepts in several significant ways. This is perhaps not unexpected since Vygotsky's theoretical backround was in no

small way influenced by Freud's writings, although Vygotsky was forced by political circumstances to conceal this influence. In one of Vygotsky's earliest papers in which he first introduces his model of the internalization of social speech, Vygotsky cites a passage from Freud's (1923) *The ego and the id,*

> Consciousness thus has a dual nature: the idea of a "double" is perhaps as near as any notion of consciousness can get to reality. This is similar to the division of the individual person into an Ego and Id, according to Freud's analytic description,"In relation to the Id, I am like a horseman who must keep rein on the outstanding strength of the horse, with a difference that the horseman tries to do this with his own forces, while I employ borrowed forces. The analogy must be extended; just as a horseman who does not want to dismount from his horse must often perforce allow himself to be taken where the horse desires, so, too the Ego ordinarily transforms the will of the id into an action that appears to be its own will." (Vygotsky, 1925/1979, p. 30)

Both Vygotsky and Freud regard the earliest social interactions, especially the earliest parent-child interactions, as having a significant influence in shaping an individual's self concept. For persons seeking psychotherapy, these early internalized interactions might be no longer appropriate (or pathological in character) and therefore become a source of conflict in the client's life.

It was suggested at the beginning of this section that the psychotherapeutic relationship achieves its result through a restructuring of the client's inner speech in order to reduce or eliminate conflictual thoughts, affective reactions, or behaviors, thereby promoting a more successful state of adjustment. In a non-directive therapeutic approach such as psychoanalysis, this interaction--and the subsequent restructuring of inner speech--

is not as evident as in more directive therapeutic modes, yet it can still be regarded an important part of the therapeutic process.

Schlessinger and Robbins (1983) research on psychoanalytic clients indicates that *the client's acquisition of the self-analytic function is the single most important outcome of a successful psychoanalytic therapy regimen.* From this perspective--which parallels Vygotsky's concept of teaching in the zone of proximal development--the client acquires enhanced self-regulatory skills as a consequence of prolonged interaction with a more capable peer (the therapist) who often, even typically, comes to be viewed unconsciously as a parent figure. While this seems a plausible explanation of the general therapeutic dynamics that underlie the therapist-client interaction, the specific way in which this transformation is accomplished in psychoanalysis is less apparent.

In classical psychoanalytic procedure, as outlined above, the therapist-client interaction consists of "drawing out" the client's repressed unconscious material through techniques such as free association and dream interpretation. The therapist might ask questions of the client, or at other times, reflect the client's questions back onto the client in order to facilitate the emergence of repressed material. Vygotsky likewise acknowledged that the process of bringing unconscious material to consciousness is essentially a process of verbalization, and that this is essentially what psychoanalysis entails (Vygotsky, 1929/1982).

On the whole the psychoanalyst does not give advice; the client ideally provides the answers to her own questions and arrives at insightful moments on her own, assisted, but not impelled, by the therapist. This therapeutic strategy may, at first, appear deliberately evasive to the client--hardly the sort of personal ambiance one might expect in an enterprise where two people are supposed to work together to resolve one individual's personal problems--and yet through this experience the client learns important lessons in self-reliance, as well as uselful techniques of self-analysis such as free association and dream interpretation. If we assume that the therapeutic ends of psychoanalysis are accomplished

by means of a Vygotskian internalization of social speech interactions with a more capable peer (the *zone of proximal development*), this is accomplished in psychoanalysis through the client's internalization of the procedures embodied in the therapy itself.

There is however, an additional dimension to psychoanalytic therapy involving the curative nature of the *transference* (the projection onto the therapist of feelings the client has had for significant persons in her life). The dynamics behind this phenomenon of transference may be partially revealed through the long term nature of psychoanalytic therapy. While short term psychotherapeutic approaches can be effective for less severe types of depression (e.g., exogenous dysthymia), larger scale problems of personality adaptation--of the sort dealt with in psychoanalysis--typically necessitate more lengthy therapeutic involvement, the duration of which is usually measured in terms of years, rather than weeks or months. During this type of therapy, the client meets with the psychoanalyst typically for an hour at a time, several days each week. This frequent, regular interaction fosters the formation of transference between the therapist and client, which provides the driving force behind the therapy. As the psychoanalyst Reuben Fine observes,

> In order to clarify this technique, the classical one introduced by Freud, it is necessary to understand the concept of *dynamic inactivity.* Usually the Freudian analyst is accused of being too passive. What is not grasped is that it is not passivity, but readiness to receive--a warm, empathic openness that allows the patient to pour his heart out. It will be noticed that the patient [does], by far, most of the talking and [comes] away with a good many insights. . . . All of this reflects the curative nature of the positive transference. Over and over in our clinic we

observed how seemingly very disturbed patients make a dramatic recovery when they form a positive transference toward their therapists.[6]

It should be noted at this point that two different forms of transference are possible, an *unconscious transference* and a *non-conflictual preconscious transference*. Both of these forms stems from a different origin, and effects the client-therapist relationship in different ways.

The *Ucs transference* originates from the client's unresolved childhood conflicts, most notably the Oedipal conflict. Normally, the child normally resolves the Oedipal dilemma by a compromise formation involving the introjection of the parental rival for the love object. This introjected parent becomes the child's superego.

In psychoanalytic therapy, the Ucs transference may be of a *positive* type (in which the client exibits dependent-erotic behavior toward the therapist) or a *negative* type (in which the client exhibits angry-accusative behavior toward therapist). In either case the memories, thoughts, and feelings that constitute the basis for the transference are not conscious, nor can they be made conscious without therapeutic intervention. Both the positive and negative forms of Ucs transference appear as a *resistance* to the process of uncovering the unconscious material during therapy, and must eventually be confronted by the therapist. In psychoanalysis, a "true" cure comes about through the conscious analysis and resolution of the client's Oedipal conflict, that is, the conflict is externalized (made conscious) and abreacted (re-experienced at the conscious level). Resolution of the Ucs transference results in permanent elimination of the client's symptoms.

In contrast, the *non-conflictual Pcs transference* manifests itself in the client as a receptive attitude toward the therapist in response to the therapist's warm, empathic

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[6] Milman, Donald S. and Goldman, George D. (1979) *Therapists at work: a demonstration of theory and technique.* Dubuque, Iowa: Kendall/Hunt Publishing Company. p. 30.

response to the client. Unlike the Ucs transference, the thoughts, memories, and feelings that motivate the Pcs transference--although they are not conscious at the moment--can be readily brought into consciousness. The Pcs transference is often spoken of as a "positive transference" because of its non-conflictual character. Unlike the dependent-erotic type of Ucs transference, this "positive transference" is not a manifestation of resistance to the therapy, in fact, it is quite the opposite; the effect of the positive transference may cause the client to suddenly feel better in an effort to please the therapist, resulting in a temporary remission of symptoms called a *transference cure*. This is the "positive transference" Reuben Fine had in mind when he spoke of its dramatic curative effects. It should be noted that the curative effect of the therapist-client transference, which appears to be so instrumental in the therapeutic process, has been interpreted in several different ways. In addition to the "insight model" (Schlessinger and Robbins) in which the client responds to emerging material by analyzing it as if it were a dream, there is also the classical "abreaction model" (Freud), as well as a "conflict resolution model" (Horney), all of which are applicable as explanations for how exactly the restructuring of inner speech brings about a change in behavior. Probably most psychotherapists would regard each of these different models as embodying a certain kind of limited truth.

The process of working through the Ucs transference to its eventual resolution has also been likened to a "re-parenting experience" (Napier and Whitaker, 1978; Steiner, 1975). This association is significant in light of the fact that the anachronism "neurosis" refers--however generally--to a category of personality dysfunctions in which unconscious repression results from an overcontrolling parental superego. In Whitaker and Napier's view, the therapist's openness to the client's most intimate and threatening memories during the therapeutic interview allows for a simultaneous externalization of these internalized conflicts, as well as for a rewriting of the internalized parental script, this time from a more adaptation-favoring, ego-supportive perspective in which the therapist acts in

the role of the parental voice. The "re-parenting experience" can be summarized as a basic restructuring of the internalized parental voice.

It has also been observed, however, that during psychoanalysis the therapist actually speaks very little. This would seem on the surface to contradict the notion of psychoanalysis involving an internalization of the therapist's social speech. There appears to be, however, a kind of inverse relationship between the quantity and the perceived significance of a therapist's utterances in such situations; a greater weight appears to be attributed to the therapist's utterances during psychoanalysis (as well as gestures, facial expressions, postures, hand shakes, et cetera), simply because they are so limited and occurs so infrequently.[7] Every word and action of the therapist takes on a sense of magnified importance, which furthers the development of the client's transference onto the therapist.

The concept of *scaffolding,* in which the therapist supports the client's efforts at critical points during the therapy by helping the client to solidify the therapeutic gains made up until that point, is a concept explored by Vygotsky and other neo-Vygotskian theorists in connection with teaching in the zone of proximal development (Wood, Bruner, Ross, 1976; Wood, 1988). In teaching, scaffolding refers to the degrees of assistance that a teacher may offer a student when that student encounters difficulty in working out a problem. The concept of collaboration must always be preserved in scaffolding; the teacher does not simply tell the answer to the student, but rather offers increased assistance in order to facilitate the student's own solution of the problem, or at other times, decreases the amount of assistance so that the student can exercise more self-regulation. In practical therapeutic application, the idea of scaffolding might involve reminding the client of the client's own significant insights at key junctures in the therapy, asking pertinent questions,

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[7] Orlinsky, David E., Ph.D., Professor in the College and Committee on Human Development, The University of Chicago. (November 1991) Personal communication.

or giving positive feedback through various forms of reinforcement in order to establish a developmental plateau from which further progress can then be attempted. It might also involve "stepping back" at times to allow the client to direct herself. Violation of the collaborative rule in scaffolding occurs when the therapist attempts to force an "insight" upon the client, rather than allow the client to discover it for himself/herself. For example, after hearing his female client's account of how fascinated she was to meet an actual prostitute, and the lengthy conversation that ensued, the inexperienced therapist remarked that perhaps the client harbored an unconscious fantasy of being a prostitute. The client's response was (predictably) one of righteous indignation at the very suggestion of any such thing.[8] Attempts by the therapist to "cut corners" during therapy inevitably fail due to the client's resistance--particularly in cases where the depth of the client's repression is great.

In psychoanalysis the curative effects of the transference, achieved through the restructuring of the internalized parental voice, occurs in a gradual, cumulative way. A significant period of time will therefore elapse before lasting therapeutic effects are evident. Because of this, it is reasonable to expect that discursive changes in the client's internalized self-regulatory voice would be more observable in longitudinal studies of client's in psychoanalysis than in observations of a single psychoanalytic interview session. Nye (1988) noted that during the course of a two-year observation of one psychoanalytic client, a global shift occurred in the tone of the client's "personal narrative" from a strictly narrative mode that consisted almost entirely of nonreflective "storytelling", to a more self-reflective analytic mode during the later portion of the analysis. Nye does not detail the exact mechanisms involved in this acquisition of analytic skill beyond a general allusion to Vygotsky and several derivative theorists. The client's shift from a "personal narrative" mode to a "personal analytic" mode is somewhat vaguely attributed by Nye to the client's internalization of the therapists's "analytic style". Nye's interpretation is consistent with

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[8] James Anderson, Ph.D., Lecturer in the Committee on Human Development, The University of Chicago. (April 1991) Lecture.

more recent research that suggests that children do not simply learn narrative skills in early social interaction, but also learn an evaluative framework for thinking about and interpreting their past experiences (Fivush, 1991). From a Vygotskian perspective, however, the exact agency can be more precisely identified as involving an internalization of the therapist's social speech, that is, his discursive interactions with the client.

In summary, client-therapist interactions in psychoanalysis, while essentially non-directive in nature, can nevertheless be conceptualized as involving both *an externalization of the client's own self-regulatory inner speech, and an internalization of the speech interactions that occur between the therapist and the client.* During the psychoanalytic process, the client becomes aware of the inadequacy of the internalized parental voice as a result of its being made conscious and, therefore, available to scrutiny. The client's internalized speech is then restructured, facilitated by the transference that forms between the therapist and client, the therapist providing assistance during this process by "scaffolding" the client's efforts. The entire process parallels, on the level of emotional self-regulation, Vygotsky's concept of teaching conceptual skills in the zone of proximal development. It is not merely happenstance that Vygotsky included emotions among the higher thought processes subject to regulation by inner speech (Vygotsky, 1932/1960).

Directive therapeutic approaches: Levels of discourse in cognitive therapy

Cognitive therapy is a structured, therapist-directed, time-limited treatment approach based upon the idea that dysfunctional behavior is due to maladaptive *cognitive schema* --put simply, the way a person perceives and organizes the world largely determines the feelings and behavior that person has toward it. In contrast to the non-directive role of the psychoanalyst, the cognitive therapist takes an active, directive, and structuring role in altering the client's dysfunctional cognitive schema by presenting evidence that challenges the client's distorted self-perceptions.

Cognitive therapy was developed by A. T. Beck in 1979 for use in the treatment of depression. Although it bears some resemblance to *Cognitive-Behavioral Therapy*, a set of therapeutic principles and procedures formulated by Meichenbaum *et al.* in 1977, the overall emphasis in cognitive therapy is upon altering dysfunctional patterns of cognition as a means of effectuating behavioral change; in contrast, Meichenbaum's Cognitive Behavioral approach relies primarily upon operant conditioning--the patient's self-statements being regarded as the principle discriminative stimuli.[9]

Whereas psychoanalytic therapy is essentially non-directive, the therapeutic approaches of both Beck and Meichenbaum involve considerable active dialogal contact between the therapist and client. The therapist's role in these interactions can be interpreted, from a Vygotskian viewpoint, as serving to restructure the client's internalized voice, the personality's principle means of self-regulation. Interestingly enough, however, *The Comprehensive Handbook of Cognitive Therapy* (1989) omits any reference to the internalization of inner speech serving as a self-regulatory function for the personality.

The following verbatim transcript from a cognitive therapy session illustrates a typical therapist-client interaction aimed at restructuring the client's dysfunctional cognitive schema. It also serves, however, to illustrate how a client's self-regulatory "inner dialogue" can be restructured with the aid of the therapist. (The careful reader will also note a pronounced Gestalt influence in the clinician's therapeutic style.) In this case, the client is a 27-year old unmarried woman who had suffered recurrent major depression and had taken a number of medication overdoses. Because the client was suicidal, and there was an urgent need to identify and challenge the assumptions underlying her current hopelessness, an active, directive style was used. The client periodically heard her mother's and sister's

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9 Sue Walrond-Skinner.(1986) *Dictionary of psychotherapy*. London: Routledge and Kegan Paul Publishers. p. 56.

voices giving her advice and criticizing her. While not hallucinations, they were vivid and disturbing.[10]

T: (1) Imagine [your mother] says, "C_____, You're completely untrustworthy." Now reply to her.

C: (2) I can't. I' m like frozen.

T: (3) Can you picture yourself getting frozen. Can you see what you're doing to freeze yourself?

C: (4). . . Because [mother] doesn't trust me . . .

T: (5) Even though she doesn't trust you, that doesn't mean you have to freeze yourself. She still doesn't trust you, but see if you can unfreeze yourself. . . What's happening?

C: (6) I'm getting mad.

T: (7) Tell your mother that you're mad that she doesn't trust you.

C: (8) I'm mad that you don't trust me. . . . She comes back, "I know you. You've been giving your grandmother trouble and she told me she asked you to do something and you wouldn't do it . . . "

T: (9) Tell your mother that what goes on between you and your grandmother is [sic] nothing to do with her.

C: (10) That's none of your business. . . . And then she'll say, "She's my mother and she's old, and when she asks you to do something, you do it."

T: (11) Tell her,"It's none of your business."

C: (12) It's none of your business

T: (13) "I'm going to make the major decisions in my life now."

C: (14) I'm going to make the major decisions in my life now . . . and then she'll say . . .

T: (15) No. "I'm not a child anymore." [The client had previously reported that her mother dreamed that she was taking the client--her sick child--to the hospital. The client said in a later session she could not envisage herself as more than 9 years old.]

C: (16) I'm not a child anymore.

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[10] Backround information and verbatim excerpt are taken from a case presented in "Cognitive restructuring through guided imagery" by David J. A. Edwards in *Comprehensive handbook of cognitive therapy* (1989) Arthur Freeman, *et al.* eds. New York: Plenum Press. pp. 290-92.

T: (17) "When you try to keep me as a child, you just make me mad."

C: (18) When you try to keep me as a child you just make me mad.

T: (19) How are you feeling now?

C: (20) Scared.

T: (21) What are you scared of?

C: (22) Her reaction . . . . She's saying,"Is this the way you treat me? After all I'm your mother."

T: (23) A classic line. A classic turn of the guilt screw. What could you reply to that?

[At this point the therapist gave her more assertive and independent words to experiment with. She was somewhat hesitant about some of the lines but, with encouragement, said them all]

C: (24) "It's true that you're my mother, but I'm not a child anymore. If we're going to relate to each other you're going to have to respect my independence. You've been treating me like a child all these years, but it's going to stop now. I'm going to have my own opinions and make my own decisions."

[At this point the client reported that her mother was just laughing at her mockingly, and the client felt hopeless because these gestures toward independence were not working. It became clear that she believed she could not individuate unless her mother changed, and she did not believe she could change her mother. The therapist summarized and reframed it for the client.]

T: (25) I get the sense that you believe you have to change her; that unless you can get her to change, to accept you and your independence, it won't be possible for you to have it.

[The therapist and client explored this for a few minutes but continually met with resistance on the part of the client to seeing a path toward true independence. this seemed to confirm the idea that her self-schema was cognitively fused with that of her mother. The next step was to test this hypothesis, and what happened confirmed this formulation.]

T: (26) I'm going to give you an idea, and that is that you have two mothers. One is sitting there at home, and the other is the one you carry around in your head. Right now it's as if you had this every manipulative, bitter woman sitting behind your shoulder whispering in your ear. Now you can't change the one who's sitting there as home, perhaps. But you don't have to have this

one sitting on your shoulder. That's the one you've created . . . . Get a picture of your mother at home, and you in the city, with this mother that you've created for yourself. See where she'd be. Would she be on your shoulder or inside your head? How would you like to picture her . . . How is she related to the image of you? . . .

C: (27) Her head is like inside mine, but it almost seems larger. There's just like my face, but then her head is larger and that's all I see.

T: (28) Now keep that image clearly. Her head's inside yours? It's like you've let her take you over? . . . Now talk to this mother who's inside your head . . . . What would you like to say to her?

C: (29) You're driving me crazy. Don't you realize all the pressure you've been putting on me. Don't you realize what it's been doing to me this last dozen of years or so?

T: (30) Let her reply.

C: (31) What do you mean? I sent you to college. I sent you on trips. I provide your food, your clothing, free housing . . .

T: (32) Stop and say to her, "You don't do anything. You're just a figment of my imagination. I created you and you're driving me crazy. And I'm not going to let this go on any longer." [Client repeats this] Tell me what's happening.

C: (33) She says, "If it weren't for me you'd never do anything. I have to push you to do everything."

T: (34) Tell her,"That's bullshit. If it weren't for you, I'd know what I wanted and I'd be able to make my own decisions."

C: (35) That's bullshit. If it weren't for you, I'd know what I wanted and I'd be able to make my own decisions. . . . Now she says,"You're so independent? Yeah, look at you! You don't have a job. You can't hold a job. You don't know what you want. You never knew how to make up your mind. "

T: (36) Tell her, "That's because I've kept you in my head like this, but I'm not going to go on like this any more."

C: (37) That's because I've kept you in my head like this, but I'm not going to go on like this any more.

T: (38) What's happening now?

C: (39) She's getting smaller . . . . She's looking at me . . .

T: (40) How do you feel now [that] she's got smaller?

C: (41) A lot calmer.

T: (42) Tell her, "I feel a whole lot better now you've got smaller. I'm going to be careful not to let you get bigger again."

C: (43) I feel a whole lot better now you've got smaller. I'm going to be careful not to let you get bigger again

T: (44) What's happening?

C: (45) Everything's going dark. She's getting smaller, and I feel a whole lot better.

[END OF TRANSCRIPTION]

The strategy used by the therapist in this interaction is straightforward. Using visualization techniques he guides the client through a imaginary interaction with her mother, the embodiment of the client's dysfunctional inner dialog. The therapist's focus upon client's mother can be seen, however, as involving more than a simple figurative metaphor which allows the client to seize hold of her problem in a "concrete" form. According to Vygotsky, the dysfunctional self-regulatory speech of the client is, at its essence, the introjected voice of the mother. It is exactly this social speech--between mother and mother--that later becomes internalized as the self-regulatory inner speech of the child. The client's image of her mother's head superimposed upon her own (line 27) presents this idea in an almost dreamlike representation.

During the therapeutic interaction, the therapist essentially coaches the client while she verbally spars with her mother. The therapist instructs the client, using basic assertiveness techniques combined with simple directive repetition, to repudiate the internalized messages of the mother, while, at the same time, substituting in their place messages of a more adaptation-favoring character. The power of the Pcs "positive" transference--the image of the therapist as a "good figure of authority"--plays an important

role in allowing the dysfunctional parental voice to be replaced by another parental voice, that of the therapist. Herein lies the essential dynamics of the "re-parenting experience" spoken of by Whitaker and Napier.

A discourse analysis of the brief verbatim transcript presented above identifies eleven rhetorical modes used by the therapist to restructure the client's inner dialogue (*see* table 1).

TABLE 1: ELEVEN RHETORICAL MODES USED BY THE THERAPIST

TYPE	MODE	INSTANCES	FREQUENCY (as % of T's total speech)
Command	1. Tell your mother . . .	11	42
Command	2. Imagine yourself . . .	2	7.7
Question	3. How are you feeling?	2	"
Question	4. What do you say?	2	"
Question	5. What's happening?	2	"
Interpretation	6. Reframe client's statement.	2	"
Command	7. Imagine your mother says . . .	1	3.8
Command	8. Unfreeze yourself.	1	"
Question	9. What are you scared of?	1	"
Command	10. Let her [mother] reply.	1	"
Command	11. Stop [mother from talking]	1	"
		Total 26	

Table one shows that 42-percent of the time the therapist told the client exactly what to say (and in each instance she repeated his words). Sixty-two-percent of the statements made by the therapist (16 statements) were explicit attempts to direct the client's conversation with her "imaginary" mother. The rhetorical modes used by the therapist could be classified further according to the level of control exercised by the therapist (in other words, the degree of scaffolding afforded to the client). For example, 65-percent (17

statements) of the statements made by the therapist were direct commands in the form of imperative sentences.

In the author's discussion of the above interaction, strikingly enough, the author never identifies this therapist-client interchange as a discursive one. The author labels it, instead, an "imagery psychodrama" and makes no reference to the processes of internalization or externalization of speech. It is clear, however, that the client's self-regulatory inner speech--cast in the form of a dialog between the client and her domineering mother--is being externalized and "rewritten" under the direct guidance of the therapist.

A question arises as to whether the statements made by the daughter when speaking for her mother are truly representative of the mother's discursive style. According to Vygotsky, inner speech is internalized social speech, which suggests that the daughter's inner dialog with the introjected mother actually replicates, or at least closely parallels, actual speech events between the mother and daughter in the past and present. Vygotsky's assertion could be verified by observing face-to-face interactions between the mother and daughter in a family therapy setting.

It is likely, however, that the daughter's introjected image of her mother contains other purely psychic accretions (such as transferences to other significant authority figures) as well as cognitive distortions stemming from the client's depressive state. The therapist alludes to the overdetermined character of the introjected mother when he mentions (line 26) that the client has two mothers: one in her head (imaginary), and one in the world (reality). In any case, the dysfunctional inner dialog appears to be closely associated with the image of the mother, however accurately or inaccurately she is portrayed. The mother-child interactions provided the "seed crystal" around which the rest of the client's dysfunctional self-dialog later crystallized. The Russian linguist Mikhail Bakhtin pointed out that all utterances have dialogic properties. On the plane of social conversation, utterances occur in the order established by the voices participating in it. It follows that, on

the plane of inner speech, a temporal succession is also established in the same manner as occurs in the alternating lines of a dialog (Bakhtin quoted in J. D. Ramirez 1992). In other words, inner speech is not simply talk, but rather *talk directed to someone*, or more accurately, talk to some other part of the self. In the case above, the client's mother has come to function as a principal interlocutor.

In a case where the observable interactions between the mother and daughter are as dysfunctional as the inner dialog represents them to be, further therapeutic intervention is necessary to modify the actual as well as the imaginary conversations between the client and her mother. Such therapeutic interventions might include family therapy as well as assertiveness training for the daughter. Many of the suggestions given by the therapist could be implemented by the daughter during actual interactions with her mother (except for those obviously directed toward the "imaginary" mother [lines 32, 36, 42]) A longitudinal follow-up study of the client's exteriorized inner speech (as manifested in therapeutic situations) would reveal the degree to which the client was able to implement the new discursive strategies taught by her therapist, and the limits to their efficacy.

It is interesting to note that dysfunctional patterns of inner speech appear to color not only subsequent client-alter interactions, but may also force upon the client a negative reassessment of interactions previously judged to have been positive (P.S. Fry 1992). This phenomenon is illustrated in the following verbatim excerpt from an interview with an elderly depressed male client.

> I've just lost my wife and she's everything I had. My children won't talk about her, and they change the subject whenever I mention her. I know they would like me to forget her and put her out of my mind, but that's not fair to her. Makes me wonder if the children ever really cared for their mother.
>
> Now my children want me to come and live with them. I say to myself,"No sir, you won't get me under your control. No sir, I'm not going to live with you." It's true my children gave

> us a very good time when we visited them last year and no matter what happened they did come to their mother's funeral. But I know things have changed between us. It will never be the same between us, and that upsets me (P.S. Fry 1992, p. 279)

As Prem S. Fry points out in the analysis of this fragment, rational and irrational belief statements compete against one another, interfering with earlier beliefs of positive parent-child relationships. The client makes arbitrary inferences about his children's lack of feelings for their mother and exaggerates the extent of the problem between him and his children . . . despite other information suggesting that the children have considerable concern for their father (P.S. Fry 1992, p. 279). In this case, as in other such cases, there is some question as to whether the dysfunctional inner speech has caused the depression, or whether the depression has caused the dysfunctional inner speech, along with other cognitive distortions. Whichever it may be, it appears that challenging these maladaptive patterns of thinking through psychotherapeutic intervention can result in a significant alleviation of the symptoms.

Meichenbaum's cognitive self-instructional training

A variant of this directive form of therapy is the *cognitive self-instructional training* procedure (SI training) developed by Donald H. Meichenbaum and Joseph Goodman in 1971. Meichenbaum and Goodman's approach applies Vygotskian theory, combined with aspects of "traditional" behaviorism, to restructure the client's inner speech, and thereby effectuate an elimination (or reduction) of the dysfunctional behavior.

Meichenbaum's earliest work focused on hyperactive children (Meichenbaum and Goodman, 1971). He has also, however, applied the same cognitive-behavioral technique to partially ameliorate the cognitive distortions that occur in schizophrenia (Meichenbaum and Cameron, 1973), to achieve stress reduction in adults (Meichenbaum, 1977), and to

increase the reading comprehension of junior high school children (Meichenbaum and Asarnow, 1979).

Meichenbaum and Goodman's SI training is a virtual application of Vygotsky's theory of inner speech to the therapist-client interaction. Their research on hyperactive-impulsive children was promulgated on the assumption that early in an individual's development, the speech of others, usually adults, mainly controls and directs a child's behavior; somewhat later, the child's own overt speech becomes an effective regulator of his behavior; and still later the child's covert or inner speech can assume a regulatory role (Meichenbaum and Goodman 1971, p. 116).

In the application of the SI training procedure to hyperactive second-grade children, the subjects first observed the experimenter performing a simple task (such as the Primary Mental Abilities Picture Matching Test) while speaking aloud the following instructions to himself.

> I have to remember to go slowly to get it right. Look Carefully at this one [the standard], now look at these carefully [the variants]. Is this one different? Yes, it has an extra leaf. Good, I can eliminate this one. Now, let's look at this one [another variant]. I think it's this one, but let me first check the others. Good, I'm going slow and carefully., Okay, I think it's this one.

After this self-verbalization behavior was modeled for the subjects, the subjects then were given similar tasks to perform--such as tracing or coloring figures, or other psychometric tests--along with varying degrees of further instruction in self-verbalization. The subjects who received the most instruction in self-verbalization were taught using a "fading" technique in which the experimenter-subject social speech was gradually reduced, allowing the subjects to exhibit the "interiorization of language" effect (Luria, 1961) as their social speech faded to partially vocalized private speech, and then--it is inferred--to self-regulatory inner speech, the final acquisition of which is presumably demonstrated by the subjects' enhanced psychometric test performance following the SI training procedure.

The application of the SI training procedure to enhance reading comprehension involved training the subjects to say certain things to themselves before, during, and after reading a selection in order to enhance their comprehension (Meichenbaum and Asarnow, 1979). A similar approach, developed for stress reduction (Meichenbaum, 1977), involved preparing for, confronting, and coping with the aftermath of stressful events.

Recent critical reviews of cognitive-behavioral interventions indicate that, with few exceptions, outcomes are restricted to short-term gains on the experimental tasks for which the children were trained (Dush, Hirt, and Schroeder, 1989; Meador and Ollendick, 1984; Whalen, Henker, and Hirshaw, 1985). These criticisms, however, fail to generalize to assessments of the subjects academic and interpersonal competence in classroom and home situations (Berk, 1992, p. 25). Diaz, Neal, and Amaya-Williams (1990) have attempted to account for these disappointing outcomes by drawing a distinction between the capacities of self-control and self-regulation. Self-control, they point out, is a simpler and earlier developmental form of behavioral control in which the child largely complies with an adult command (such as "Don't touch!"), then repeats the command in the adult's absence. The effectiveness of self-control is limited to situations that are similar to the original instance of controlled behavior. In contrast, the capacity of self-regulation involves the ability of an individual to orchestrate an entire constellation of such self-regulatory commands, along with some degree of flexibility in their implementation, all directed toward some well-defined goal. The acquisition of such skills are, according to Vygotsky, particularly associated with collaborative interactions in the zone of proximal development. From this perspective, the cognitive-behavioral approach fails to achieve long-term results because cognitive therapy is a training-focused form rather than a collaboration-focused one (Berk 1992, p. 26). An alternative explanation may involve the time-limited nature of cognitive-behavioral psychotherapy; simply not enough time is spent on-task to allow for the skills to become permanently ingrained, generalized, and applied in the wider spheres of the client's experience.

Ironically, this suggests that psychoanalysis' non-directive, long-term approach seems to be more effective at achieving lasting outcomes in the enhancement of a client's self-regulatory ability than more directive, short-term SI training.

Discussion

In the examples cited above, both the overcontrolled (neurotic) adult and the undercontrolled (hyperactive-impulsive) children experienced a positive therapeutic effect, either of a short-term or a long-term nature, from speech interactions with a therapist. This presumably occurred as a consequence of the restructuring of the clients/subjects' self-regulatory inner speech. In psychoanalytic therapy (Nye, 1988) the effect of the therapy was partially manifested in the transformation of the client's self-narrative from a non-analytic to a more analytic mode, which occurred gradually over a long term and within the context of that nondirective therapeutic approach. In the cognitive-behavioral approach (Meichenbaum) the therapeutic intervention followed a more directive mode and the effects were evident over a relatively shorter time period, although these gains were also, as other research has indicated, probably of a more limited, short-term nature.

Although it is not usually regarded in this way, psychoanalysis may be considered as basically a teaching process through which the client learns more adaptation-favoring emotional responses through speech interactions with the therapist. These interactions appear to follow the Vygotskian model for the internalization of speech, moving from social speech, to private (covert) speech, and finally, to inner (internalized) speech.

Vygotsky considered speech to be a tool-like mediational mechanism through which thoughts can be manipulated as if they were objects. Internalized social speech is not only a kind of tool in this more limited sense, but also a self-regulatory instrument for the personality. Vygotsky's model suggests that dysfunctional patterns of inner speech will, consequently, lead to dysfunctional patterns of behavior.

While the "interiorization of speech"--to use Luria's phrase--usually follows the pattern of *social--private--inner* speech, certain variations exist within this continuum. Studies on the quasi-social nature of private speech have tested Jean Piaget's claim that children would engage most in private speech when left alone (1923) and have found Piaget to be wrong (Vygotsky 1934/1986). In a series of studies conducted early in this century, Vygotsky found that childrens' private speech increased or decreased in direct proportion to the availability of a listening audience. Children spoke aloud most when someone else was within hearing distance, spoke less when they were in a room with children who spoke only a foreign language, even less when sharing a room with deaf children, and least of all when they were completely alone; exactly the opposite of what Piaget claimed would occur. Subsequent research by Western psychologists has also found that the kind of egocentric speech reported by Piaget makes up only about 3-percent of childrens' external self-talk (Berk 1992). The observed increase in private speech when a listening audience is present reflects both the social origin and underlying quasi-social character of private speech.

Although a number of studies have described the abbreviated character of private speech as it becomes internalized (Azmitia 1992, Berk 1985, Berk and Garvin 1984, Furrow 1992, Kohlberg *et al.* 1968, Tharp and Gallimore 1988, Vygotsky 1934/1986) few observational transcripts have been provided to illustrate this phenomenon. When older children who are working silently are asked to verbalize their thoughts, the result resembles the private speech of younger children. As an aid for understanding this process of speech internalization, the following simulated specimens are offered to demonstrate the sorts of speech patterns that occur at various stages along the continuum that moves from social speech, to private speech, to inner speech. This simulation depicts the development of a nominal social-private-inner speech pattern as it would appear in longitudinal observations over several sessions.

LEVEL ONE: Social speech:
(Simulated interaction between a mother and child in an observational setting)

M: OK, let's draw. Would you like that? Here is your crayon. Now, what shall we draw?

C: [shrugs] I don't know.

M: How about daddy? Why don't we draw daddy.

C: Daddy?

M: Here, watch me. First you make a circle, and then you make his eyes and his nose.

C: [C points to drawing] Here's his eyes, and his nose.

M: That's right. Now you make one.

LEVEL TWO: Early private speech (simulated):

[Child draws alone]

C: Now I'm drawing daddy. First, make a circle.

C: And here's his eyes, here's his nose. That's right.

LEVEL THREE: Later abbreviated private speech (simulated):
[Child draws alone in a later observational session]

C: Daddy ... [whispers inaudibly] . . . a cir-. . . a circle . . .

C: First eyes . . . then [mumbles] . . . OK

LEVEL FOUR: Private speech (simulated):
[verified by *ex post facto* report of the child's thoughts while drawing]

E: Can you tell me what you were thinking while you were doing this drawing?

C: Here's my daddy. First I draw his eyes, then I draw his nose.

Each of these simulated interactions illustrates a stage in the transformation from social speech, to private speech, to inner speech. First, the social interaction between mother and

child provides the child with a basic algorithmic sequence for approaching the task, in this case, producing a likeness of the father (Level 1). The child's early private speech (level 2) reproduces the mothers basic instructions, and becomes more fragmentary and abbreviated as the degree of internalization proceeds (level 3). Inner speech is, of course, not manifestly observable in the same way that social or private speech is, however, its existence and content can be verified in an *ex post facto* manner (level 4) by asking the subject to report what he/she was thinking about while silently engaged in the act of drawing. In some instances, the demonstration of an acquired behavior (or cessation of a dysfunctional behavior) may be sufficient to verify the internalization of self-regulatory speech.

The following actual verbatim transcript (Ramirez, 1992, pp. 206-207) illustrates the portion of the interiorization continuum represented above as "later private speech" (level 3). Note how abbreviated and fragmentary the private speech suddenly becomes in the very last lines of the interaction (lines 9 and 10). This transcript is a translation (the original language is Spanish), and involves three persons: the experimenter (E), a young boy (B), and a young girl (G).)

B: (1) (Addresses the Experimenter) I've done my daddy.

E : (2) That's fine. You can draw other things like a house or a car . . . whatever you like.

B: (3) I'm going to do a car. I'm going to do my daddy's car. [B continues to address E]

G: (4) [whispers inaudibly while she draws]

B: (5) [Addressing G] Are you going to do a car too?

G: (6) No. [She does not look up]

[A period of time passes during which B has not drawn anything special]

B: (7) [Addresses E] I know what I'm going to do.

E: (8) What are you going to do?

B: (9) I'm going to do . . .

[E goes away without answering, then B continues to talk while he begins to draw, looking only at his paper. His voice diminishes until it is just a whisper]

C: (10) . . . the chair . . . the cha- . . . [followed by inaudible whispers]

In addition to the usual form of private speech represented in this excerpt, there exists another anomalous form--quasi-social speech--in which an individual presumably engaged in private (self-directed) speech, does so loudly enough that strangers in the immediate vicinity cannot help but overhear the person's "private" utterances. Such quasi-social speech often lacks the fragmentary, abbreviated character of later private speech, and may serve as a special kind of non-committal social interaction, a signal to alter of the other's presence, or may serve to express dominance or histrionic intentions. While Vygotsky demonstrated that vocalization of private speech increased in the presence of an available audience, the form of quasi-social speech just described can perhaps be regarded as a regressive, egocentric type of social interaction invoked by the speaker when a greater degree of control is desired than that of standard social intercourse.

Encounters with certain stressful situations also appear to result in a regressive increase in private speech. A frequently encountered example of this occurs in the common proclivity to engage in private speech when attempting to find one's way through a maze of complex mathematical algorithms. Such utterances serve to consciously direct the thought processes when a crisis situation demands a higher degree of self-regulation than that usually required. The speaker in essence re-instructs himself, assuming the role of the original speech-mentor relative to himself.

Criticisms of Vygotsky's inner speech model

From the point of view of clinical psychology, Vygotsky's model might be criticized not so much for a lack of internal consistency (for it appears to be both complete and elegantly descriptive), but rather from the standpoint that it might not accurately represent a true

etiological factor in mental illness. In other words, dysfunctional inner speech might be only a prominent symptom, rather than a cause of mental illness--or it may play a variety of different roles.

Research on inner speech poses persistent methodological problems. Since the interiorization of language can only be empirically observed in a partial way through observations of private speech, and sometimes only through *ex post facto* techniques, inner speech is, and most probably will remain, a highly subjective phenomenon. In the face of these difficulties, one alternative approach has been to divert the focus of the inquiry away from empirical studies to an exegesis of the linguistic-semiological features of inner speech (or, as some prefer to call it "inner dialog"). The writings of Russian linguist, Mikhail Bakhtin, a contemporary of Vygotsky, have attracted a good deal of recent attention in this regard. Bakhtin's work, which asserts that all utterances involve dialogic properties, addresses itself to the hermeneutic dimensions implicit in dialogic utterances--including such issues as who are the interlocutors when one engages in inner speech; the question "Who is doing the talking?" will always be answered, from a Bakhtinian perspective, "At least two voices" (Wertsch, 1991). Bakhtin's semiological investigations, however, seem vulnerable to the same criticism frequently leveled by anthropologists against Claude Levi-Strauss--namely, that his work is too narrowly "intellectualistic" to be of much use to most practitioners in the field, and too abstruse to be of much interest to anyone outside of it--to say nothing of the fact that Bakhtin's work anticipated domains that have since been well-explored by personality and role theorists such as Erving Goffman and Harry Stack Sullivan. Revealingly enough, Bakhtin's work receives its most cordial reception from other linguists rather than from psychological clinicians.

In defense of Vygotsky's work it should be said that although present techniques of empirical verification limit the degree to which the entire continuum of social-private-inner speech can be studied, one can nevertheless marshall supporting evidence, as in the realm of jurisprudence, to validate Vygotsky's claims regarding the existence and self-regulatory

function of inner speech. This approach is consistent with post-Kuhnian perspectives on the history and philosophy of science which have demonstrated that 19th-century logical positivism--the belief that science studies only observable phenomena that are real ontological truths--has become an intellectual anachronism. At some levels science, like law, is a discursive enterprise. Ironically, the father of empirical psychology Wilhelm Wundt himself may have had something like this in mind when he turned from his "hard science" research in psychophysics to his *Völkerpsychologie* studies on the cultural-psychological aspects of myth and literature.

These same methodological limitations make the question of whether inner speech is the cause or merely the consequence of mental illness an unanswerable one, at least at present. Research has demonstrated, however, that both children and adults incorporate features of social speech interactions in their own private speech, and that similarities exist between externalized thoughts, previous social speech interactions, and private speech. These dimensions constitute the various dimensions of discourse in psychotherapeutic interactions and suggest strategies for the treatment of mental illnesses and for approaching more closely an understanding of the exact nature of the therapeutic process.

Conclusion

At the outset of this paper three questions were posed concerning the levels of discursive interaction in psychotherapy. The answers to these three questions constitute a general summary of this monograph.

(1) *What role--or roles--does verbalization play in psychotherapy?* Verbalization in psychotherapy plays at least two distinct roles. First, verbalization allows a client to externalize her self-regulatory inner speech, making it available for conscious analysis and revision. Second, the speech interactions that occur between therapist and client during psychotherapy become the basis for subsequent revisions of the client's inner dialog. The

internalization of more adaptation-favoring patterns of inner speech can be observed as a significant outcome in both directive and non-directive forms of therapy.

(2) *How important is verbalization to the successful outcome of the therapy?* Both directive and non-directive therapeutic styles make extensive use of discursive interaction as the fundamental "medium of exchange" between therapist and client. The act of making something conscious largely involves putting it into words. Thus, verbalization is an integral part of any psychotherapeutic technique that aims at making previously inaccessible psychical material available for conscious analysis and revision. (As Wittgenstein observed in his *Philosophical Investigations*, "There are things we know but cannot say, and these things we must pass over in silence.")

(3) *What specific levels of discourse can be identified in psychotherapeutic interactions?* Vygotsky's developmental model of inner speech effectively illustrates the discursive levels of psychotherapeutic interaction, which move from *social speech* (communicative and/or directive speech between a therapist and client), to *private speech* (self-regulatory speech directed by a client to herself), and finally, to *inner speech* (the internalized social dialog which functions as the essential self-regulatory instrument for the personality).

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